

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037754

Facility Name: The Imperial Grove Pavilion

Address: 1366 West Fullerton Chicago 60614
Number City Zip Code

County: Cook

Telephone Number: (773) 539-2122 Fax # (773) 935-0036

IDPA ID Number: 363796886001

Date of Initial License for Current Owners: 01/31/92

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover Telephone Number: (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
Paid Preparer	(Signed) SEE ACCOUNTANTS' COMPILATION REPORT	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606	
	(Telephone) (312) 634-3400 Fax # (312) 634-5518	
	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion

0037754 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>248</u>	Skilled (SNF)	<u>248</u>	<u>90,520</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>248</u>	TOTALS	<u>248</u>	<u>90,520</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>66,931</u>	<u>7,140</u>	<u>6,667</u>	<u>80,738</u>	8
9	SNF/PED					9
10	ICF	<u>3,588</u>	<u>886</u>		<u>4,474</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>70,519</u>	<u>8,026</u>	<u>6,667</u>	<u>85,212</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 94.14%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☒ NO ☐ Non-allowable costs have been
eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 01/31/1992

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 01/01/1998 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 50 and days of care provided 6,667

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	390,541	7,386	749,421	1,147,348		1,147,348	(60,588)	1,086,760			1
2	Food Purchase		139,052		139,052		139,052	(52)	139,000			2
3	Housekeeping	117,571	64,107	297,960	479,638		479,638	12,700	492,338			3
4	Laundry		21,723	189,600	211,323		211,323		211,323			4
5	Heat and Other Utilities			305,739	305,739		305,739	3,731	309,470			5
6	Maintenance	88,851	60,892	154,297	304,040		304,040	4,524	308,564			6
7	Other (specify):*											7
8	TOTAL General Services	596,963	293,160	1,697,017	2,587,140		2,587,140	(39,685)	2,547,455			8
	B. Health Care and Programs											
9	Medical Director			18,500	18,500		18,500		18,500			9
10	Nursing and Medical Records	3,177,598	257,573	147,966	3,583,137		3,583,137		3,583,137			10
10a	Therapy	24,363		335,106	359,469		359,469		359,469			10a
11	Activities	112,346	59,558	2,576	174,480		174,480		174,480			11
12	Social Services	56,859		5,288	62,147		62,147		62,147			12
13	Nurse Aide Training			2,310	2,310		2,310		2,310			13
14	Program Transportation			597	597		597		597			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,371,166	317,131	512,343	4,200,640		4,200,640		4,200,640			16
	C. General Administration											
17	Administrative	106,467		174,807	281,274		281,274	(174,807)	106,467			17
18	Directors Fees											18
19	Professional Services			181,103	181,103		181,103	(9,692)	171,411			19
20	Dues, Fees, Subscriptions & Promotions			43,887	43,887		43,887	8,420	52,307			20
21	Clerical & General Office Expenses	561,479	57,179	93,229	711,887		711,887	27,810	739,697			21
22	Employee Benefits & Payroll Taxes			665,078	665,078		665,078	128,669	793,747			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,683	5,683		5,683	2,173	7,856			24
25	Other Admin. Staff Transportation			18,331	18,331		18,331	(2,401)	15,930			25
26	Insurance-Prop.Liab.Malpractice			155,311	155,311		155,311	708	156,019			26
27	Other (specify):*											27
28	TOTAL General Administration	667,946	57,179	1,337,429	2,062,554		2,062,554	(19,120)	2,043,434			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,636,075	667,470	3,546,789	8,850,334		8,850,334	(58,805)	8,791,529			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7**	8			
30	Depreciation			154,520	154,520		154,520	456,489	611,009			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			217,295	217,295		217,295	1,300,412	1,517,707			32
33	Real Estate Taxes							350,493	350,493			33
34	Rent-Facility & Grounds			1,849,920	1,849,920		1,849,920	(1,849,920)				34
35	Rent-Equipment & Vehicles			4,719	4,719		4,719	2,401	7,120			35
36	Other (specify):*											36
37	TOTAL Ownership			2,226,454	2,226,454		2,226,454	259,875	2,486,329			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		272,847	780	273,627		273,627		273,627			39
40	Barber and Beauty Shops	30,388	664		31,052		31,052		31,052			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			135,780	135,780		135,780		135,780			42
43	Other (specify):* Nonallowable costs			345,680	345,680		345,680	(345,680)				43
44	TOTAL Special Cost Centers	30,388	273,511	482,240	786,139		786,139	(345,680)	440,459			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,666,463	940,981	6,255,483	11,862,927		11,862,927	(144,610)	11,718,317			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See schedule of adjustments attached at end of cost report

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(52)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,313	30		9
10	Interest and Other Investment Income	(39,934)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	1,192	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,941)	43		18
19	Entertainment				19
20	Contributions	(35,180)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(190,354)	43		24
25	Fund Raising, Advertising and Promotional	(90,018)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See Schedule 5A</u>	(133,960)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (490,934)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	346,324		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 346,324		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (144,610)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line
		Reference	
1	Deferred maintenance cost (net)	\$ 850	6 1
2	Disallow patient clothing	(8,900)	43 2
3	Personal use of auto income	(2,401)	25 3
4	Offset cable tv, telephone income	(523)	21 4
5	Legal fees for Real Estate Taxes	7,869	33 5
6	Legal fees for Real Estate Taxes	(11,745)	19 6
7	To disallow out of period legal fees	(6,988)	19 7
8	Disallow Rebillable Lab/X-Ray	(17,479)	43 8
9	Nonallowable real estate taxes	(94,643)	33 9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(133,960)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Imperial Grove Pavilion

0037754

Report Period Beginning:

01/01/01

Ending:

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	4,129	0	0	0	0	0	0	0	0	4,129	1
2	Food Purchase	(52)	0	0	0	0	0	0	0	0	0	0	(52)	2
3	Housekeeping	0	0	12,700	0	0	0	0	0	0	0	0	12,700	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	3,731	0	0	0	0	0	0	0	0	3,731	5
6	Maintenance	850	0	3,674	0	0	0	0	0	0	0	0	4,524	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	798	0	24,234	0	0	0	0	0	0	0	0	25,032	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(155,562)	(19,245)	0	0	0	0	0	0	0	(174,807)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(18,733)	0	8,173	868	0	0	0	0	0	0	0	(9,692)	19
20	Fees, Subscriptions & Promotions	0	0	1,399	7,021	0	0	0	0	0	0	0	8,420	20
21	Clerical & General Office Expenses	(523)	0	26,141	2,192	0	0	0	0	0	0	0	27,810	21
22	Employee Benefits & Payroll Taxes	0	0	59,608	4,344	0	0	0	0	0	0	0	63,952	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	2,147	26	0	0	0	0	0	0	0	2,173	24
25	Other Admin. Staff Transportation	(2,401)	0	0	0	0	0	0	0	0	0	0	(2,401)	25
26	Insurance-Prop.Liab.Malpractice	0	0	708	0	0	0	0	0	0	0	0	708	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(21,657)	0	(57,386)	(4,794)	0	0	0	0	0	0	0	(83,837)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(20,859)	0	(33,152)	(4,794)	0	0	0	0	0	0	0	(58,805)	29

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Robert Hartman	30.00%	See Attached Schedule 6H		ITEX Mgmt. Co.	Lincolnwood	Management Co.
Barry Carr	10.00%			AK Care	Lincolnwood	Management Co.
Michael Harris	20.00%			Care Path Health	Lincolnwood	
Jack Rajchenbach	20.00%			Network		Management Co.
Bernard Hollander	20.00%			The Claridge, LLC	Lincolnwood	Lessor
				Claridge Ivy, LTD	Lincolnwood	Retirement Comm.
				JLR Management	Lincolnwood	Management Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 1,849,920	The Claridge, L.L.C.	100.00%	\$	\$ (1,849,920)	1
2	V	30	Depreciation Building		The Claridge, L.L.C.	100.00%	360,933	360,933	2
3	V	30	Depreciation Equipment		The Claridge, L.L.C.	100.00%	71,840	71,840	3
4	V	32	Interest		The Claridge, L.L.C.	100.00%	1,286,187	1,286,187	4
5	V	32	Amortization of Loan Cost		The Claridge, L.L.C.	100.00%	21,287	21,287	5
6	V	33	Property Taxes		The Claridge, L.L.C.	100.00%	429,919	429,919	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,849,920			\$ 2,170,166	\$ * 320,246	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	ITEX Management Company & AK Care	70.00%	\$ 4,129	\$ 4,129	15
16	V	3	Housekeeping		ITEX Management Company & AK Care	70.00%	12,700	12,700	16
17	V	5	Utilities		ITEX Management Company & AK Care	70.00%	3,731	3,731	17
18	V	6	Repairs and Maintenance		ITEX Management Company & AK Care	70.00%	3,674	3,674	18
19	V	17	Management Fees	155,562	ITEX Management Company & AK Care	70.00%		(155,562)	19
20	V	19	Professional Fees		ITEX Management Company & AK Care	70.00%	8,173	8,173	20
21	V	20	Dues, Subscriptions, Licenses		ITEX Management Company & AK Care	70.00%	1,399	1,399	21
22	V	21	Offices Expenses		ITEX Management Company & AK Care	70.00%	26,141	26,141	22
23	V	22	Employee Benefits		ITEX Management Company & AK Care	70.00%	59,608	59,608	23
24	V	24	Education and Seminars		ITEX Management Company & AK Care	70.00%	2,147	2,147	24
25	V	26	Insurance		ITEX Management Company & AK Care	70.00%	708	708	25
26	V	30	Depreciation Expense		ITEX Management Company & AK Care	70.00%	21,403	21,403	26
27	V	32	Interest & Amortization Exp		ITEX Management Company & AK Care	70.00%	32,872	32,872	27
28	V	33	Real Estate Taxes		ITEX Management Company & AK Care	70.00%	7,348	7,348	28
29	V	35	Equipment Rental		ITEX Management Company & AK Care	70.00%	2,401	2,401	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 155,562			\$ 186,434	\$ * 30,872	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	\$19,245	Care Path Health Network	70.00%	\$	\$ (19,245)	15
16	V	19	Professional Fees		Care Path Health Network	70.00%	868	868	16
17	V	20	Dues, Subscriptions, Licenses		Care Path Health Network	70.00%	7,021	7,021	17
18	V	21	Office Expenses		Care Path Health Network	70.00%	2,192	2,192	18
19	V	22	Employee Benefits		Care Path Health Network	70.00%	4,344	4,344	19
20	V	24	Education and Seminar		Care Path Health Network	70.00%	26	26	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$19,245			\$14,451	\$ * (4,794)	39

NAME OF FACILITY

PROVIDER #

12/31/2001

The Imperial, Grove Pavilion

0037754

Schedule 6H

VII. RELATED PARTIES
RELATED NURSING HOMES
PART A COLUMN 2

NAME	CITY
CLARK MANOR	CHICAGO, IL
CHEVY CHASE CORPORATION	CHICAGO, IL
HALSTED TERRACE	CHICAGO, IL
JACKSON CORPORATION	CHICAGO, IL
GLENVIEW TERRACE	GLENVIEW, IL
HARMONY NURSING & REHABILITATION	CHICAGO, IL
MONROE CORPORATION	CHICAGO, IL
CALIFORNIA GARDENS CORPORATION	CHICAGO, IL
CLARIDGE HOUSE	NORTH MIAMI, FL
RENAISSANCE HILLSIDE	HILLSIDE, IL
CARLTON AT THE LAKE	CHICAGO, IL
REGENTS PARK OF BOCA RATON	BOCA RATON, FL
SOUTH SHORE RENAISSANCE	CHICAGO, IL
RENAISSANCE 87 TH STREET	CHICAGO, IL
RENAISSANCE MIDWAY	CHICAGO, IL
REGENTS PARK OF ADVENTURA	ADVENTURA, FL

See Accountants' Compilation Report

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Barry Carr	Administrative	Exec. Admin	10.00%	*322011	5	11.00	Salary	\$ 1,714	L17, C1	1
2	David Hartman	Administrator	Administrator	0.00%	*18074	40	89.00	Salary	103,038	L17, C1	2
3	Michael Harris	Administrative	Administrative	20.00%		5	11.00	Salary	1,715	L17, C1	3
4			* see attached schedule 7A								4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 106,467		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

The Imperial, Grove Pavilion
0037754
12/31/2001

Schedule 7A

VII. RELATED PARTIES (continued)
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board Of Directors.
Compensation Received From Other Nursing Homes

Name	Harmony	Renaissance 87th St.	Renaissance Hillside	Renaissance Midway	Renaissance S.Shore	California	Chevy	Jackson	Monroe	Total
Barry Carr	0	55,874	51,992	61,372	57,714	28,429	31,094	22,210	13,326	322,011
David Hartman	0	2,169	1,446	2,530	2,169	2,892	3,253	2,169	1,446	18,074
										0
Total Compensation Received From Other Nursing Homes	0	58,043	53,438	63,902	59,883	31,321	34,347	24,379	14,772	340,085

Facility Name & ID Number The Imperial Grove Pavilion# 0037754

Report Period Beginning:

01/01/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization ITEX Management CompanyStreet Address 6633 North Lincoln AvenueCity / State / Zip Code Lincolnwood, IL. 60645Phone Number (847) 676-2122Fax Number (847) 679-4606

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Bed days available	462,455	5	\$ 21,096	\$	90,520	\$ 4,129	1
2	3	Housekeeping	Bed days available	462,455	5	64,883		90,520	12,700	2
3	5	Utilities	Bed days available	462,455	5	19,061		90,520	3,731	3
4	6	Repairs and Maintenance	Bed days available	462,455	5	11,765		90,520	2,303	4
5	6	Scavenger and Exterminating	Bed days available	462,455	5	7,004		90,520	1,371	5
6	19	Accounting Fees	Bed days available	462,455	5	5,762		90,520	1,128	6
7	19	Data Processing	Bed days available	462,455	5	33,334		90,520	6,525	7
8	19	Legal Fees	Bed days available	462,455	5	2,655		90,520	520	8
9	20	Classified Advertising	Bed days available	462,455	5	653		90,520	128	9
10	20	Dues and Subscriptions	Bed days available	462,455	5	2,005		90,520	392	10
11	20	Employment Recruitment Fees	Bed days available	462,455	5	4,493		90,520	879	11
12	21	Bank Services Charges	Bed days available	462,455	5	957		90,520	187	12
13	21	Office Supplies	Bed days available	462,455	5	38,547		90,520	7,545	13
14	21	Postage	Bed days available	462,455	5	50,587		90,520	9,902	14
15	21	Telephone	Bed days available	462,455	5	43,369		90,520	8,489	15
16	21	Annual Report	Bed days available	462,455	5	90		90,520	18	16
17	22	Holiday Expense	Bed days available	462,455	5	7,090		90,520	1,388	17
18	24	Education and Seminars	Bed days available	462,455	5	10,970		90,520	2,147	18
19	26	Insurance	Bed days available	462,455	5	3,618		90,520	708	19
20	30	Depreciation	Bed days available	462,455	5	109,347		90,520	21,403	20
21	32	Amortization Loan Costs	Bed days available	462,455	5	1,165		90,520	228	21
22	32	Interest Expense	Bed days available	462,455	5	166,773		90,520	32,644	22
23	33	Real Estate Taxes	Bed days available	462,455	5	37,542		90,520	7,348	23
24	35	Equipment Rental	Bed days available	462,455	5	12,264		90,520	2,401	24
25	TOTALS					\$ 655,030	\$		\$ 128,214	25

SEE ACCOUNTANTS' COMPILATION REPORT

#	0037754	Report Period Beginning:	01/01/01	Ending:	12/31/01
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Name of Related Organization	Care Path Health Network
Street Address	6633 North Lincoln Avenue
City / State / Zip Code	Lincolnwood, IL 60645
Phone Number	(847) 676-2122
Fax Number	(847) 679-4606

B. Show the allocation of costs below. If necessary, please attach worksheets.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion# 0037754

Report Period Beginning:

01/01/01

Ending:

12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Lincoln National Life Insurance		x	Mortgage ***	\$80,255.00	09/1/89	\$ 6,254,345	\$ 5,672,808	09/01/07	0.1050	\$ 605,533	1	
2	Lincoln National Life Insurance		x	Mortgage ***	\$13,595.00	09/1/89	1,036,602	943,218	09/01/07	0.1088	104,227	2	
3	Lincoln National Life Insurance		x	Mortgage ***	\$6,538.00	11/1/92	509,189	470,047	11/01/07	0.1094	52,121	3	
4	LaSalle National Bank		x	Mortgage	\$64,321.00	10/1/98	7,345,625	6,988,776	10/01/23	0.0744	524,228	4	
5	Hill Rom		x	Purchase of Equipment	\$890.00	3/16/00	21,357	1,780	03/15/02	0.1000	723	5	
	Working Capital												
6	LaSalle National Bank	x		Line of Credit	Interest only	12/14/00	3,000,000		12/14/01	P+.0050	210,958	6	
7	LaSalle National Bank	x		Line of Credit	Interest only	12/22/01	3,500,000	2,600,000	08/14/02	P+.0075	3,414	7	
8												8	
9	TOTAL Facility Related				\$165,599.00		\$ 21,667,118	\$ 16,676,629			\$ 1,501,204	9	
	B. Non-Facility Related*												
10	From Page 9A						557,202	552,087			2,278	10	
11								Interest income offset			(39,934)	11	
12	*** These loans were assumed by The Claridge L.L.C. as of 10/1/98 under the same terms as the original mortgage holder							Amortization of mortgage cost			21,287	12	
13								Allocated from management co.			32,872	13	
14	TOTAL Non-Facility Related						\$ 557,202	\$ 552,087			\$ 16,503	14	
15	TOTALS (line 9+line14)						\$ 22,224,320	\$ 17,228,716			\$ 1,517,707	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME THE IMPERIAL, GROVE PAVILION
PROVIDER # 0037754
PERIOD 12/31/2001

SCHEDULE 9A

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

Name of Lender	Related		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
	YES	NO				Original	Balance			
A. Directly Facility Related Long-Term										
Wells Fargo		X	Purchase of Equipment	298	8/30/2000	\$ 7,202	\$ 2,087	8/30/2002	0.0933	\$ 587
Working Capital										
Shareholders Loans	X		Working Capital	Interest Only	12/21/2000	550,000	550,000	12/31/2002	0.0800	0
										0
										0
TOTAL Facility Related										
				298		\$ 557,202	\$ 552,087			\$ 587
B. Non-Facility Related										
						\$	\$			\$
						Miscellaneous interest expense				1,691
TOTAL Non-Facility Related										
						\$ 557,202	\$ 552,087			\$ 2,278

See Accountants' Compilation Report

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.		<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>		\$	504,767	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2000		\$	467,646	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(37,121)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	467,040	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	7,869	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.						
TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	350,493	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

1996	451,410	8
1997	475,537	9
1998	483,979	10
1999	480,730	11
2000	467,646	12

** 2000 real Estate Tax Bill	467,646	* 2000 Total Real Estate Tax Bill	556,721
Estimated Increase	1	Imperial portion for financial stmt	467,646 84%
2001 Accrual	467,040	Imperial portion for cost report	373,003 67%
		Adjustment	(94,643)

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

The Imperial Grove Pavilior

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0037754

CONTACT PERSON REGARDING THIS REPORT

James Slesur

TELEPHONE (773) 539-2122

FAX #: (773) 935-0036

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2000

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	14-29-321-040	Nursing Home	\$ 556,721.00	\$ 467,646.00
2.	10-35-312-022	Nursing Home	\$ 39,270.00	\$ 7,348.00
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 595,991.00	\$ 474,994.00

B. **Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? x YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 91,703 B. General Construction Type: Exterior Brick Frame Reinforced Concrete Number of Stories 6

C. Does the Operating Entity? (a) Own the Facility (X) (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (X) (a) Own the Equipment (X) (b) Rent equipment from a Related Organization. (X) (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Claridge Lincoln Park, Ltd; Retirement apartments rental; 119 units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES (X) NO If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Resident Care	Not		1998		\$ 40,000	
2		Available					
3	TOTALS					\$ 40,000	

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	248		1998	1984	\$ 14,437,336	\$	40	\$ 360,933	\$ 360,933	\$ 1,173,032	4
5											5
6			1993	1993	313,974		35	8,971	8,971	76,998	6
7											7
8											8
	Improvement Type**										
9	Leasehold Improvements			1992	60,378	3,032	20	3,032		28,803	9
10	Leasehold Improvements			1993	59,308	2,965	20	2,965		25,203	10
11	Leasehold Improvements			1994	10,638	532	20	532		3,990	11
12	Leasehold Improvements			1995	43,191	2,160	20	2,160		14,040	12
13	Furnace			1996	1,843	92	20	92		506	13
14	Door Locks			1996	2,357	118	20	118		649	14
15	Windows			1996	8,365	418	20	418		2,299	15
16	Electrical Wiring			1996	4,880	244	20	244		1,342	16
17	Fence			1996	1,067	53	20	53		292	17
18	Gutters			1996	1,574	79	20	79		434	18
19	Brick Wall			1996	2,560	128	20	128		704	19
20	Ceiling Lights			1996	5,501	274	20	274		1,509	20
21	Nurse Station			1996	2,500	124	20	124		683	21
22	Countertops			1996	2,610	131	20	131		719	22
23	Convection Oven			1996	7,515	376	20	376		2,067	23
24	Boiler			1996	2,927	146	20	146		803	24
25	Fence			1997	1,050	53	20	53		238	25
26	Electrical Improvements			1997	1,671	84	20	84		378	26
27	Nurse Call Station			1997	3,501	175	20	175		788	27
28	Public Address System			1997	1,360	68	20	68		306	28
29	Brick Wall			1997	5,110	256	20	256		1,152	29
30	Floor Tile			1997	21,705	1,085	20	1,085		4,883	30
31	Fire Doors			1997	4,096	205	20	205		922	31
32	Carpeting			1997	3,243	162	20	162		729	32
33	Inspection Improvements			1997	9,884	494	20	494		2,223	33
34	Door Restrictors			1997	8,475	424	20	424		1,908	34
35	Fire Alarm			1997	2,082	103	20	103		465	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Sheet Metal	1998	\$ 11,981	\$ 599	20	\$ 599	\$	2,097	37
38	Lighting	1998	7,156	358	20	358		1,253	38
39	Screens	1998	2,704	135	20	135		473	39
40	Piping	1998	4,145	207	20	207		725	40
41	Fire Alarms & Fire Proofing	1998	12,534	627	20	627		2,194	41
42	Tile	1998	967	49	20	49		171	42
43	Driveway	1998	7,342	367	20	367		1,285	43
44	Tuckpointing	1998	39,242	1,962	20	1,962		6,866	44
45	Ground Fuel Tank	1999	17,985	899	20	899		2,248	45
46	Carpet	1999	28,114	1,406	20	1,406		3,515	46
47	Wallcovering	1999	36,585	1,830	20	1,830		4,574	47
48	Floor in Dining Room	1999	9,850	493	20	493		1,232	48
49	Signs	1999	1,765	88	20	88		220	49
50	Electrical Work	1999	20,508	1,025	20	1,025		2,563	50
51	Brick & Masonry Work	1999	12,345	617	20	617		1,542	51
52	Gas Line Improvements	1999	1,633	82	20	82		205	52
53	Alarm System	1999	1,388	69	20	69		173	53
54	Wallcovering	2000	21,554	1,078	20	1,078		1,617	54
55	Flooring	2000	13,293	664	20	664		996	55
56	Carpet	2000	8,284	414	20	414		621	56
57	Over Bed Lights	2000	4,593	230	20	230		345	57
58	Compactor	2000	6,800	340	20	340		510	58
59	Paging System	2000	9,909	496	20	496		744	59
60	CCTV System	2000	5,456	272	20	272		408	60
61	Wander Guard System	2000	18,540	928	20	928		1,392	61
62	Handrails, Kickplates, Wallbases	2000	6,038	302	20	302		453	62
63	Fuel Tank Project	2000	1,444	72	20	72		108	63
64	FirstQ System	2000	1,378	68	20	68		102	64
65	Chain Link Fence	2000	745	38	20	38		57	65
66	Alarm System	2000	5,051	252	20	252		378	66
67	Service P.A. System	2000	1,924	96	20	96		144	67
68	Remodel 13 Bedrooms	2000	18,112	906	20	906		1,359	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 15,370,066	\$ 30,950		\$ 400,854	\$ 369,904	\$ 1,388,635	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 15,370,066	\$ 30,950		\$ 400,854	\$ 369,904	\$ 1,388,635	1
2	Repair Elevator	2000	990	50	20	50		75	2
3	Remodel Smoking Room	2000	23,565	1,178	20	1,178		1,767	3
4	Remodel Old Smoking Room to Library	2000	4,690	234	20	234		351	4
5	Remodel 1st Floor	2000	10,540	528	20	528		792	5
6	Remodel 6th Floor Dining Room	2000	4,970	248	20	248		372	6
7	Remodel 3rd Floor Dining Room	2000	959	48	20	48		72	7
8	Call Station	2000	4,475	224	20	224		336	8
9	Landscaping	2000	2,785		n/a				9
10	Roof repair	2001	3,830	96	20	96		96	10
11	Masonry repair	2001	15,227	381	20	381		381	11
12	Stainless steel toilet bars	2001	1,645	40	20	40		40	12
13	Masonry repair	2001	3,700	93	20	93		93	13
14	New tile	2001	3,633	91	20	91		91	14
15	Tile coating	2001	4,540	114	20	114		114	15
16	New Wanderguard system	2001	4,407	110	20	110		110	16
17	New relay rack	2001	3,788	95	20	95		95	17
18									18
19	Allocated from Management Company	1993	39,507		20	1,976	1,976	17,198	19
20	Allocated from Management Company	1994	21,220		20	1,061	1,061	7,726	20
21	Allocated from Management Company	1995	3,616		20	181	181	1,121	21
22	Allocated from Management Company	1996	205		20	10	10	62	22
23	Allocated from Management Company	1997	6,101		20	305	305	1,373	23
24		1999	678		20	34	34	102	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 15,535,137	\$ 34,480		\$ 407,951	\$ 373,471	\$ 1,421,002	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,892,872	\$ 113,585	\$ 185,425	\$ 71,840	10	\$ 875,237	71
72	Current Year Purchases	47,278	2,365	2,365		10	2,365	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt. Co. & Related Parties	112,905		11,178	11,178		63,290	74
75	TOTALS	\$ 2,053,055	\$ 115,950	\$ 198,968	\$ 83,018		\$ 940,892	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	1994 Ford Van	1994	\$ 30,750	\$	\$	\$	5 yrs	\$ 30,750	76
77	Patient Care	1998 Ford Van	1999	20,449	4,090	4,090		5 yrs	10,225	77
78										78
79										79
80	TOTALS			\$ 51,199	\$ 4,090	\$ 4,090	\$		\$ 40,975	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 17,679,391	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 154,520	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 611,009	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 456,489	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,402,869	85

**

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☒ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☒ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 7,120
- Description: Medical Eq. \$ 967; Copier \$ 3,752; Allocated from Mgmt Co \$ 2,401
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	N/A				18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year Ending
- Annual Rent
12. /2002 \$
13. /2003 \$
14. /2004 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☒ YES

☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☒

HOURS PER AIDE40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☒

IN OTHER FACILITY☐

HOURS PER AIDE80

B. EXPENSES

ALLOCATION OF COSTS (d)

		12		3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 2,310	\$	\$ 2,310
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 2,310	\$	\$ 2,310
10	SUM OF line 9, col. 1 and 2 (e)	\$ 2,310			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$N/A

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	7
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	
TOTAL TRAINED	11

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L 10a, C3	hrs	\$	7,433	\$ 111,554	\$	7,433	\$ 111,554	1
2	Licensed Speech and Language Development Therapist	L 10a, C3	hrs		2,119	33,803		2,119	33,803	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L 10a, C3	hrs		11,402	174,498		11,402	174,498	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L 39, C2	# of prescripts				238,160		238,160	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See attached Sch. 16A		1297	24,363	16	780	34,687	1,313	59,830	13
14	TOTAL			\$ 24,363	20,970	\$ 320,635	\$ 272,847	22,267	\$ 617,845	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

PROVIDER NAME IMPERIAL
PROVIDER # 0037754
PERIOD 12/31/2001

SCHEDULE 16A

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8					
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units of Service	Cost	Units	Cost								
							13a	OTHER: Oxygen	L39, C2		hrs	\$		\$
13b	Air Floatation Mattress	L39, C2						16,261			16,261	13b		
13c	Licensed Respiratory Therapist	L10a,C1	1297 hrs	24,363				1,297	24,363			13c		
13d	Transportation	L39, C3	hrs		16	780		16	780			13d		
			visits									13e		
			visits									13f		
			hrs											
			hrs											
			# of prescrpts											
			hrs											
13	TOTAL			\$	24,363	16	\$	780	\$	34,687	1,313	\$	59,830	13

SEE ACCOUNTANTS' COMPILATION REPORT

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 576,778	\$ 576,778	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 350,000)	4,377,638	4,377,638	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	109,161	109,161	6
7	Other Prepaid Expenses	367,893	367,893	7
8	Accounts Receivable (owners or related parties)	185,461	1,151,171	8
9	Other(specify): See Schedule 17A	655,140	655,140	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,272,071	\$ 7,237,781	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,785	42,785	13
14	Buildings, at Historical Cost		14,822,636	14
15	Leasehold Improvements, at Historical Cost	709,975	709,716	15
16	Equipment, at Historical Cost	1,272,954	2,104,254	16
17	Accumulated Depreciation (book methods)	(828,489)	(2,402,869)	17
18	Deferred Charges		425	18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Loan Costs		227,186	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,157,225	\$ 15,504,133	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,429,296	\$ 22,741,914	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 497,621	\$ 497,621	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	62,527	62,527	28
29	Short-Term Notes Payable	3,867	3,867	29
30	Accrued Salaries Payable	247,217	247,217	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	87,108	87,108	31
32	Accrued Real Estate Taxes(Sch.IX-B)		467,040	32
33	Accrued Interest Payable	13,355	119,156	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,216,401	1,216,401	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,128,096	\$ 2,700,937	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,150,000	17,224,849	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,150,000	\$ 17,224,849	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,278,096	\$ 19,925,786	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,151,200	\$ 2,816,128	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,429,296	\$ 22,741,914	48

FACILITY NAME THE IMPERIAL, GROVE PAVILION
PROVIDER # 0037754
12/31/2001

Schedule 17A

XV. BALANCE SHEET - Unrestricted Operating Fund.
A. Current Assets

Other (specify):	Operating	After Consolidation
Employee Loans	52,133	52,133
Due from AK Care	77,583	77,583
Due from Related Parties	525,424	525,424
Total Line 9 - Other(specify):	655,140	655,140

C. Current Liabilities

Other Current Liabilities (specify):	Operating	After Consolidation
Due to Related Parties	348,446	348,446
Short Term Loan Exchanges	7,335	7,335
Resident Credit Balances	734,430	734,430
Other Accrued Expenses	126,190	126,190
Total Line 36 - Other Current Liabilities(specify):	1,216,401	1,216,401

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,474,969	1
2	Restatements (describe):		2
3			3
4	Rounding	(1)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,474,968	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	676,232	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 676,232	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,151,200	24 *

Operating entity only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,516,440	1
2	Discounts and Allowances for all Levels	(308,941)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,207,499	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	802,395	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 802,395	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	26,862	13
14	Non-Patient Meals	52	14
15	Telephone, Television and Radio	78	15
16	Rental of Facility Space		16
17	Sale of Drugs	339,995	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	55,198	19
20	Radiology and X-Ray		20
21	Other Medical Services	54,273	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 476,458	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	39,934	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 39,934	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	12,873	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,873	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,539,159	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,587,140	31
32	Health Care	4,200,640	32
33	General Administration	2,062,554	33
	B. Capital Expense		
34	Ownership	2,226,454	34
	C. Ancillary Expense		
35	Special Cost Centers	650,359	35
36	Provider Participation Fee	135,780	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,862,927	40
41	Income before Income Taxes (line 30 minus line 40)**	676,232	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 676,232	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
Entity is a cash basis taxpayer

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

FACILITY NAME: THE IMPERIAL, GROVE PAVILION
PROVIDER # 0037754
12/31/2001

Schedule 19A

XVII. INCOME STATEMENT
Revenue

<u>E. Other Revenue (specify):</u>	<u>Amount</u>
Miscellaneous Income	310
Vending Commission	12,428
Wage Assignment Fees	<u>135</u>
Total Line 28 - Other Revenue (specify):	<u><u>12,873</u></u>

See Accountants' Compilation Report

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,159	2,199	\$ 97,997	\$ 44.56	1
2	Assistant Director of Nursing	5,593	6,037	147,475	24.43	2
3	Registered Nurses	32,613	33,984	846,243	24.90	3
4	Licensed Practical Nurses	37,662	39,353	704,244	17.90	4
5	Nurse Aides & Orderlies	113,308	119,315	1,044,339	8.75	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,275	1,297	24,363	18.78	7
8	Rehab/Therapy Aides	6,740	7,359	75,611	10.27	8
9	Activity Director					9
10	Activity Assistants	15,239	15,726	112,346	7.14	10
11	Social Service Workers	2,483	2,539	56,859	22.39	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	13,415	14,486	160,859	11.10	14
15	Cook Helpers/Assistants	34,123	35,825	229,682	6.41	15
16	Dishwashers					16
17	Maintenance Workers	7,538	7,786	88,851	11.41	17
18	Housekeepers	16,181	17,039	117,571	6.90	18
19	Laundry					19
20	Administrator	2,000	2,080	106,467	51.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,924	23,248	561,479	24.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health CaSee Sch 20a	10,603	11,330	261,689	23.10	32
33	Other(specify) Beautician	1,894	2,014	30,388	15.09	33
34	TOTAL (lines 1 - 33)	324,750	341,617	\$ 4,666,463 *	\$ 13.66	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 30710	L1, C3	35
36	Medical Director	Monthly	18500	L9, C3	36
37	Medical Records Consultant	147	6820	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1800	L10, C3	39
40	Physical Therapy Consultant	190	9488	L10A, C3	40
41	Occupational Therapy Consultant	85	4250	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	30	1513	L10A, C3	43
44	Activity Consultant	56	2576	L11, C3	44
45	Social Service Consultant	5	338	L12, C3	45
46	Other(specify)				46
47	Religious Services	Monthly	4950	L12, C3	47
48					48
49	TOTAL (lines 35 - 48)	513	\$ 80,945		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	511	\$ 21,880	L10, C3	50
51	Licensed Practical Nurses	3,158	117,466	L10, C3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	3,669	\$ 139,346		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name

The Imperial Grove Pavilion

PROVIDER #

0037754

Period Ending

12/31/01

Schedule 20A

XVIII. STAFFING AND SALARY COSTS

	Hours Worked	Hours Paid	Salary	Avg Hr Wage	Cost Report Line
Ward Clerk	5,733	6,244	65,380	\$ 10.47	10
Nursing Administrative	4,870	5,086	196,309	\$ 38.60	10
Total Line 32 - Other Health Care	10,603	11,330	\$ 261,689	\$ 23.10	

See Accountants' Compilation Report

Facility Name & ID Number **The Imperial Grove Pavilion**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	Ownership %	Amount
David Hartman	Administrator	0.00%	\$ 103,038
Barry Carr	Administrative	10.00%	1,714
Michael Harris	Administrator	20.00%	1,715
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 106,467
B. Administrative - Other			
Description			Amount
Management Fees (eliminated in column 7)		\$	174,807
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 174,807
C. Professional Services			
Vendor/Payee	Type		Amount
Personnel Planners, Inc	Unemployment Consulting	\$	1,465
Power Software Development	Computer Consulting		11,348
Extended Care Com	Computer Consulting		3,840
Healthcare Horizon	Computer Consulting		1,170
Susan Fox	Accounting		14,940
American Express Tax & Business	Accounting		5,823
Frost, Ruttenberg & Rothblatt, P.C.	Accounting		23,550
Commitment Consulting	Accounting		14,954
Altschuler, Melvoin & Glasser LLP	Accounting		26,908
Structural Engineering Services	Architectural		750
Sachnoff & Weaver, Ltd.	Legal		877
See Attached Schedule 21 A			75,478
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 181,103
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	61,721
Unemployment Compensation Insurance			47,842
FICA Taxes			337,694
Employee Health Insurance			153,911
Employee Meals			64,717
Illinois Municipal Retirement Fund (IMRF)*			
Chicago Head Tax			8,828
Miscellaneous Employee Benefits			25,694
Tuition Reimbursement			5,020
Uniforms			7,983
Christmas Expenses			11,373
401K Plan			5,012
Allocated from Management Company			63,952
TOTAL (agree to Schedule V, line 22, col.8)			\$ 793,747
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
N/A			
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	
Advertising: Employee Recruitment			17,602
Health Care Worker Background Check (Indicate # of checks performed 131)			1,886
Illinois Council on Long-Term Care			9,475
JCAHO			2,986
Various Dues, Subscriptions, & Manuals			5,012
Various Inspections			5,069
Various Licenses & Permits			1,857
Allocated from Management Co.			8,420
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 52,307
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			1,331
Seminar Expense			4,352
Allocated from Management Co.			2,173
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	7,856

*** Attach copy of IMRF notifications**
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

FACILITY NAME The Imperial, Grove Pavilion
PROVIDER # 0037754
12/31/2001

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount	
Segal & Segal	Legal	\$ 30,222	
Vedder Price	Legal	20,361	
Klein Dub & Holleb, Ltd.	Legal	2,138	
Stone, McGuire & Benjamin	Legal	7,005	
Madigan & Getzendanner	Legal	11,745	
Guardianship Services Assoc.	Legal	1,554	
AK Care	Data Processing	1,283	
Medi	Data Processing	1,110	
American Express	Data Processing	60	
TOTAL (agree to Schedule V, Attached Schedule 21A)		\$ 75,478	
TOTAL (agree to Schedule V, line 19, column 3)			181,103
Professional fees allocated from Itex			
Computer Consulting		\$ 6,525	
Legal		520	
Accounting		1,128	
Total from Itex			8,173
Professional fees allocated from Care Path Health Network			
Computer Consulting		\$ 513	
Legal		287	
Accounting		68	
Total from Care Path Health Network			868
Subtotal			\$ 190,144
Reclass Madigan & Getzendanner Legal fee for Real Estate Tax			(11,745)
Less: Non-Allowable Professional Fees			
Sachnoff & Weaver, Ltd. -Wrong entity		\$ (140)	
Vedder Price - Out of Period		(5,897)	
Guardianship Services Assoc. - Out of Period		(220)	
Klein Dub & Holleb, Ltd. - Invoices counted twice		(731)	
Total Non-Allowable Professional Fees			(6,988)
Total Allowable Professional Services (Schedule V line 19, column 8)			\$ 171,411

See Accountants' Compilation Report

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Repairs to Chiller	02/28/99	\$ 2,550	3	\$	\$ 425	\$ 850	\$ 850	\$ 425	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 2,550		\$	\$ 425	\$ 850	\$ 850	\$ 425	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

#0037754

Report Period Beginning:01/01/01

Ending:12/31/01

Page 23

Facility Name & ID NumberThe Imperial Grove Pavilion

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

Yes

(2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

Yes
Illinois Council on Long-Term Care \$ 9475

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

Yes
Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
10 yrs

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 15,026
Line 10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
N/A

(9)

Are you presently operating under a sublease agreement?

YES
X

NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES
NO
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

X
N/A

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 135,780

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
For example, is a portion of the building used for rental, a pharmacy, day care, etc.)
If YES, attach a schedule which explains how all related costs were allocated to these functions.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 64,717
No

Indicate the amount. \$ 0

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No
N/A

c.

What percent of all travel expense relates to transportation of nurses and patients?

0%

d.

Have vehicle usage logs been maintained?

Adequate records are maintained

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:
The instructions for the cost report require that a copy of this audit be included with the cost report.
Has this copy been attached?

No
N/A
N/A

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes

(19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees.

Yes

SEE ACCOUNTANTS' COMPILATION REPORT

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	390,541	7,386	749,421	1,147,348	0	1,147,348	-60,588	1,086,760
2. Food Purchase	0	139,052	0	139,052	0	139,052	-52	139,000
3. Housekeeping	117,571	64,107	297,960	479,638	0	479,638	12,700	492,338
4. Laundry	0	21,723	189,600	211,323	0	211,323	0	211,323
5. Heat and Other Utilities	0	0	305,739	305,739	0	305,739	3,731	309,470
6. Maintenance	88,851	60,892	154,297	304,040	0	304,040	4,524	308,564
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	596,963	293,160	1,697,017	2,587,140	0	2,587,140	-39,685	2,547,455
9. Medical Director	0	0	18,500	18,500	0	18,500	0	18,500
10. Nursing & Medical Records	3,177,598	257,573	147,966	3,583,137	0	3,583,137	0	3,583,137
10a. Therapy	24,363	0	335,106	359,469	0	359,469	0	359,469
11. Activities	112,346	59,558	2,576	174,480	0	174,480	0	174,480
12. Social Services	56,859	0	5,288	62,147	0	62,147	0	62,147
13. Nurse Aide Training	0	0	2,310	2,310	0	2,310	0	2,310
14. Program Transportation	0	0	597	597	0	597	0	597
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	3,371,166	317,131	512,343	4,200,640	0	4,200,640	0	4,200,640
17. Administrative	106,467	0	174,807	281,274	0	281,274	-174,807	106,467
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	181,103	181,103	0	181,103	-9,692	171,411
20. Fees, Subscriptions & Promotion	0	0	43,887	43,887	0	43,887	8,420	52,307
21. Clerical & General Office	561,479	57,179	93,229	711,887	0	711,887	27,810	739,697
22. Employee Benefits & Payroll	0	0	665,078	665,078	0	665,078	128,669	793,747
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	5,683	5,683	0	5,683	2,173	7,856
25. Other Admin. Staff Trans	0	0	18,331	18,331	0	18,331	-2,401	15,930
26. Insurance-Prop.Liab.Malpractice	0	0	155,311	155,311	0	155,311	708	156,019
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	667,946	57,179	1,337,429	2,062,554	0	2,062,554	-19,120	2,043,434
29. Total General Administrative	4,636,075	667,470	3,546,789	8,850,334	0	8,850,334	-58,805	8,791,529
30. Depreciation	0	0	154,520	154,520	0	154,520	456,489	611,009
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	217,295	217,295	0	217,295	1,300,412	1,517,707
33. Real Estate	0	0	0	0	0	0	350,493	350,493
34. Rent - Facility & Grounds	0	0	1,849,920	1,849,920	0	1,849,920	-1,849,920	0
35. Rent - Equipment & Vehicles	0	0	4,719	4,719	0	4,719	2,401	7,120
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	2,226,454	2,226,454	0	2,226,454	259,875	2,486,329
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	272,847	780	273,627	0	273,627	0	273,627
40. Barber and Beauty Shop	30,388	664	0	31,052	0	31,052	0	31,052
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	135,780	135,780	0	135,780	0	135,780
43. Other (specify):*	0	0	345,680	345,680	0	345,680	-345,680	0
44. Total Special Cost Ce	30,388	273,511	482,240	786,139	0	786,139	-345,680	440,459
45. Grand Total	4,666,463	940,981	6,255,483	11,862,927	0	11,862,927	-144,610	11,718,317

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	576,778	576,778
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	4,377,638	4,377,638
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	109,161	109,161
7. Other Prepaid Expenses	367,893	367,893
8. Accounts Receivable-Owner/Related Party	185,461	1,151,171
9. Other (specify):	655,140	655,140
10. Total current assets	6,272,071	7,237,781
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	2,785	42,785
14. Buildings, at Historical Cost	0	14,822,636
15. Leasehold Improvements, Historical Cost	709,975	709,716
16. Equipment, at Historical Cost	1,272,954	2,104,254
17. Accumulated Depreciation (book methods)	-828,489	-2,402,869
18. Deferred Charges	0	425
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	227,186
24. Total Long-Term Assets	1,157,225	15,504,133
25. Total Assets	7,429,296	22,741,914
CURRENT LIABILITIES		
26. Accounts Payable	497,621	497,621
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	62,527	62,527
29. Short-Term Notes Payable	3,867	3,867
30. Accrued Salaries Payable	247,217	247,217
31. Accrued Taxes Payable	87,108	87,108
32. Accrued Real Estate Taxes	0	467,040
33. Accrued Interest Payable	13,355	119,156
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	1,216,401	1,216,401
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	2,128,096	2,700,937
LONG TERM LIABILITES		
39.Long-Term Notes Payable	3,150,000	17,224,849
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	3,150,000	17,224,849
46.Total Liabilities	5,278,096	19,925,786
47.Total Equity	2,151,200	2,816,128
48.Total Liabilities and Equity	7,429,296	22,741,914

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	11,516,440
2. Discounts and Allowances for all Levels	-308,941
Subtotal - Inpatient Care	11,207,499
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	802,395
7. Oxygen	0
Subtotal - Ancillary Revenue	802,395
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	26,862
14. Non-Patient Meals	52
15. Telephone, Television, and Radio	78
16. Rental of Facility Space	0
17. Sale of Drugs	339,995
18. Sale of Supplies to Non-Patients	0
19. Laboratory	55,198
20. Radiology and X-Ray	0
21. Other Medical Services	54,273
22. Laundry	0
Subtotal - Other Operating Revenue	476,458
24. Contributions	0
25. Interest and Other Investments Income	39,934
Subtotal - Non-Operating Revenue	39,934
27. Other Revenue (specify):	12,873
28. Other Revenue (specify):	0
Subtotal - Other Revenue	12,873
30. Total Revenue	12,539,159
31. General Services	2,587,140
32. Health Care	4,200,640
33. General Administration	2,062,554
34. Ownership	2,226,454
35. Special Cost Centers	650,359
35. Provider Participation Fee	135,780
37. Other	0
40. Total Expenses	11,862,927
41. Income Before Income Taxes	676,232
42. Income Taxes	0
43. Net Income or Loss for the Year	676,232

Page

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10 Attachment of Real Estate Bill and fill out form

11

12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached

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19 The bottom right side of page under **, you must write in any comments

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RECONCILIATION REPORT

The Imperial Grove Pavi03:06 PM11/07/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-144,610	equal to	-144,610	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	1,517,707	equal to	1,517,707	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	350,493	equal to	350,493	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	611,009	equal to	611,009	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	7,120	equal to	7,120	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	2,310	equal to	2,310	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	24,363	equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	335,106	equal to	359,469	-24,363	FAILED	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	272,847	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	2,587,140	equal to	2,587,140	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	4,200,640	equal to	4,200,640	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	2,062,554	equal to	2,062,554	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	2,226,454	equal to	2,226,454	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	650,359	equal to	650,359	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+†	N/A	38to41+43	4
Income Stat. Prov. Partic.	135,780	equal to	135,780	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,840,298	equal to	3,177,598	-337,300	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	24,363	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	112,346	equal to	112,346	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	56,859	equal to	56,859	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	390,541	equal to	390,541	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	88,851	equal to	88,851	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	117,571	equal to	117,571	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to		0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	106,467	equal to	106,467	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	561,479	equal to	561,479	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	4,666,463	equal to	4,666,463	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	30,710	< or = to	749,421	-718,711	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	18,500	< or = to	18,500	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	147,966	< or = to	147,966	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	2,576	< or = to	2,576	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	338	< or = to	5,288	-4,950	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	106,467	equal to	106,467	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	174,807	equal to	174,807	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	181,103	equal to	181,103	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	793,747	equal to	793,747	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	52,307	equal to	52,307	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	7,856	equal to	7,856	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	135,780	equal to	135,780	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	64,717	< or = to	128,669	-63,952	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	64,717	equal to	64,717	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	6,667	equal to	6,667	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	346,324	equal to	346,324	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4†	B.	14	8
Total loan balance	17,228,716	equal to	17,228,716	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	467,040	equal to	467,040	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	40,000	equal to	42,785	-2,785	FAILED	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	15,535,137	equal to	15,532,352	2,785	FAILED	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	2,104,254	equal to	2,104,254	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	2,402,869	equal to	2,402,869	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	2,151,200	equal to	2,151,200	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	676,232	equal to	676,232	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	425	equal to	425	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	7,429,296	equal to	7,429,296	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1